Draft Findings on Nursing Home Finances

Health Care Finance Working Group

Presented to the Governor's Health Care Task Force
on Behalf of the Working Group by

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A. Introduction

This report on nursing home finances is the second in a series of reports prepared by the Health Care Finance Working Group convened by Secretary O'Leary. I have been asked to report on behalf of the members of the Working Group, and gratefully acknowledge the contributions of staff from the Executive Office of Health and Human Services and the Division of Health Care Finance and Policy.

As with the Working Group's first report, on hospital care and hospital finances in the Commonwealth, we have found a problem that warrants continuous state monitoring and observation, with an eye toward helping to design durable solutions, and to plan for all reasonable contingencies.

In other words, as with hospitals, we are recommending sustained state engagement with a group of vital caregivers. State government cannot simply wait for the phone to ring. It has to anticipate contingencies, and make itself ready to cope with them by identifying, testing, and preparing responses.

Government must act because nursing homes rely heavily on public money, especially from Medicaid, and because some 50,000 residents of the Commonwealth—almost one percent of the state's population—depend on nursing home care.

Although this report addresses nursing home finances specifically, it certainly does not recommend ignoring the rest of the long-term care world generally. Indeed, the growing need for long-term care in the years ahead, as the number of people over age 85 rises, will present great challenges. Meeting these challenges will require creative solutions. Devising, testing, and implementing those solutions will require public, private, community-level, and family-level efforts.

B. Findings

1. Our task force has examined nursing home finances in the Commonwealth and finds that some homes are experiencing financial difficulty. About one-quarter of the state's nursing home beds are owned by corporations that have filed for bankruptcy. Some 55 percent of the 474 homes that accepted Medicaid patients lost money in 1998, the last year for which data are available. The mean loss that year was 3.06 percent and the median loss was 0.63 percent. (The financial figures are expected to look more favorable when the nursing homes that do not accept Medicaid patients are included in the totals.)

2. Financial problems of nursing homes appear to be associated with difficulty in retaining and recruiting enough direct caregivers, and consequently with reduced quality of care to nursing home residents.

3. The need for long-term care, including nursing home care, is expected to rise in the decades ahead. Our state's nursing homes need to be put on a durably sustainable financial footing. This should be done as part of a systematic examination of long-term care needs and resources for meeting them.

C. Causes

Our Working Group identified a number of possible causes of nursing homes' financial problems.

1. Changes in the mix of payors and in the adequacy of overall payment levels.

- Massachusetts nursing homes rely more heavily on Medicaid than do those in most other states. A greater share of residents are covered by Medicaid.

- Medicaid payment levels have been set with the intention of covering the costs of efficiently operated nursing homes.

- Nursing homes traditionally relied on payors other than Medicaid to generate surpluses of revenue over cost, to balance lower Medicaid payments. But privately paying patients have declined as a share of the statewide total of nursing home residents. This is partly because assisted living facilities have been built to serve higher-income patients who can afford assisted living. (Medicaid does not cover assisted living.)

- In the 1990s, many nursing homes increased their capacity to serve Medicare patients, some of whom were being discharged sooner from acute care hospitals. For a time, Medicare patients generated surpluses for nursing homes, but these surpluses fell markedly after passage of the federal Balanced Budget Act of 1997.

2. Many Massachusetts nursing homes have been bought by national chains. It appears that these chains often paid premium prices to acquire Massachusetts homes, even though state law has for decades prohibited recognizing higher

purchase prices when setting Medicaid rates. And a nursing home with more debt in proportion to its assets was very substantially and fairly consistently more likely to suffer a negative profit margin.

An analysis prepared by staff to the Working Group found a substantial association (a Pearson product-moment correlation of -0.42) between a nursing home's total profit margin in 1998 and its debt-to-asset ratio in that year.

3. Ironically, in the present tight labor market, already-weak nursing home finances have been made worse in some instances by their very weakness. That is, a number of nursing homes have been unable to pay wages high adequate to retain or attract enough full-time workers. This has sometimes forced them to turn to temporary nursing agencies to secure direct care workers, and this has driven up the nursing homes' costs still higher, worsening their finances further.

D. Responses

We considered these three options:

1. Doing nothing and letting the problem play out.

2. An across-the-board bail-out of the nursing home industry.

3. A short-term state intervention to help stabilize the state's nursing homes, in combination with serious longer-term contingency planning and analysis of both the problems, causes, and solutions to nursing homes' financial problems, and of the larger long-term care world generally.

1. Doing nothing is not acceptable because:

- Many nursing homes suffer serious financial problems.

- We see no reason to expect substantial improvement soon.

- If some homes are forced to close, there is little reason to expect that those would disproportionately be the homes that the state and its nursing home residents can afford to do without.

- In the months or years before a financially distressed nursing home closes, quality of care can suffer. Patients can be harmed.

- Some nursing homes may emerge from bankruptcy without enough money to finance safe, adequate, and decent patient care.

- When a home does close, residents' lives can be disrupted by relocation.

- If most—or even many—of homes operated by corporations in bankruptcy were to close, the state lacks enough alternative caregivers—nursing homes, assisted living facilities, home care agencies, and others—to provide enough substitute care to serve the residents displaced by nursing home closings. Empty nursing home beds statewide equal only about one-tenth the total number of beds in homes owned by bankrupt corporations, for example.

- Given the large state role in paying for nursing homes through Medicaid, state government has a responsibility to act to protect quality of care and an adequate supply of beds where they are needed.

2. An across-the-board bail-out is not affordable and does not seem to be appropriate because:

- Increasing payments to all homes would provide windfall profits to homes that are already profitable while barely stabilizing those that are losing substantial sums.

- Given the substantial association (r_p = -0.42) between a nursing home's debt-to-equity ratio and its profitability, an across-the-board payment rise could be seen as inappropriately rewarding corporate owners that paid too much money to buy nursing homes.

- It is inappropriate to reward financial miscalculations or bad management.

- Providing more money to individual homes, including those owned by bankrupt national chains, would probably not do enough to move the chains themselves out of bankruptcy. This would leave the future of their Massachusetts homes uncertain.

- Across-the-board aid would be costly. With Medicaid spending roughly $1.2 billion on nursing homes annually, a one percent rise in payments would cost Medicaid roughly $13-15 million. That is because Medicaid would have to pay a disproportionate share of the increase.

- The overall bail-out would violate the Commonwealth's policy of prospective payment of nursing homes to encourage efficiency. It would signal a wide turn back toward cost-reimbursement.

3. We propose taking 12 specific steps in all:

Five of these are short-term:

a. Targeted state financial aid, perhaps through Medicaid. It could focus on retaining and attracting needed caregivers to work in nursing homes, with the aim of protecting and improving the quality of care for nursing home residents. .

b. Increasing state capacity to monitor quality of care and to intervene when necessary.

c. Special targeted help through loans, grants, and technical assistance.

d. Use of nursing home receivership when necessary, perhaps including state purchase of bankrupt homes and contracting out their management.

e. Possibly, creative approaches to addressing staffing problems.

It will be important to analyze legal aspects of implementing each method.

Taking any of these five short-term steps should be coordinated with intermediate and long-range planning for nursing homes and long-term care generally. We identify seven longer-term steps:

a. Monitoring and analysis.

- Enhanced overall monitoring of the financial conditions of the states nursing homes.
- Developing better methods of identifying nursing homes that require more money—homes that are losing money even though operated efficiently.
- Investigating why some nursing homes seem to do well financially and deliver higher-quality care, even in the present climate—while others clearly do not—and developing appropriate interventions.
- Auditing nursing home spending specifically to ensure that additional state payments are not used to pay off debts or to cover excessive administrative costs.

b. Identifying nursing homes that are vital owing to geographic access, or the specialized care they provide.

c. Developing ways to diversify nursing homes' payor mix, to reduce reliance on Medicaid.

d. Contingency planning—planning for the contingency of widespread or profound deterioration in quality of care, small- or large-scale threatened closings, and the like. This should include planning for large-scale receivership and continued operation. And it should also include planning for adequate Medicaid payments even at the bottom of a serious recession.

e. Coordinating nursing home care and nursing home payments with broader long-term care planning in general—including home health care, other home care, and also more innovative methods of assuring safe,

f. Continuing improvement in coordination between the departments of state government that deal with nursing home finances, Medicaid payments, and nursing home quality. This should entail improved state government knowledge of homes' quality, efficiency, and related matters—county-by-county, home-by-home.

g. Considering more creative and exploratory approaches to long-term care finance generally, as we face the risk of going down a dead end.

E. In Conclusion

Please consider these four paradoxes and dilemmas.

1. Most older and disabled people prefer to live at home, yet most public long-term money is used to finance nursing homes. This is partly because state aid understandably goes first to people in the greatest need, and partly because nursing homes are usually less costly sites of care for people in the greatest need.

2. Despite these high public payments, many nursing homes face financial difficulties, and quality of care appears to be suffering as well.

3. Despite today's high spending, costs are likely to rise in the future, as the number of people aged 80 and above continues to increase.

4. Some solutions look like they will save money but tend not to do so. Many reform that appear promising result in repackaging the same costs in different bundles. Long-term care is inherently very costly because it entails paying one person to provide a great amount of care to another person. Just consider how many hours of help any of us would require if we were to become frail or disabled and could not get out of bed.

Looking ahead, we need creative approaches that will give safe, adequate, dignified, and acceptable care to our disabled, frail, or medically unstable citizens—and care that is durably affordable.

This will require real experimentation. It will require new combinations of paid and unpaid care, new ideas about how families, communities, and publicly paid services can sustain people who need long-term care.

All this will require a sustained commitment and creativity by state government, and we are glad that the state is doing this work.